Camp TBI Registration Agreement
July 13, 2020 – August 21, 2020

Child's Name: _____ Birth Date: _____ Gender: _____

Home Address: _____ Age as of September 1, 2020 _____

_____

Parent/Guardian #1 Name: _____ Cell Phone: _____

Home Address: _____ Home Phone: _____

_____ Email: _____

Parent/Guardian #2 Name: _____ Cell Phone: _____

Home Address: _____ Home Phone: _____

_____ Email: _____

TBI Membership Status: (Circle One) TBI MEMBER NON-MEMBER

Would you like Membership Information sent to you? YES NO THANK YOU

This application must be accompanied by a **Non-Refundable Registration Fee** and a Tuition Deposit at the rates stated below. Tuition Deposits will get rolled into Tuition in the month of August.

TBI Member Registration Fee: $25.00 Non-Member Registration Fee: $75.00

TBI Member Tuition Deposit: $150.00 Non-Member Tuition Deposit: $150.00

The Leonard & Madlyn ECEC at TBI offers the following Discounts/Incentives:
Sibling Discount (FOR NON-MEMBERS ONLY): 10% off tuition for the first sibling, 5% off tuition for each additional sibling. All discounts are applied to the oldest child/children.

ENROLLMENT CONTRACT:

I agree to be responsible for the payment of all registration fees and tuitions, as set forth in the enrollment selection form for the 2020 Camp TBI session, regardless of whether or not my child(ren) attend school for the entire year. I understand that timely payments are a requirement of enrollment and late payments may result in the removal of my child(ren) from the Leonard & Madlyn Abramson ECEC at TBI. I understand and agree that no tuition or registration fees will be refunded or transferred toward any TBI program or fees if my child(ren) do not attend school for any part of the session, including absences, snow days, emergencies, holidays or vacations. I hereby agree to the above terms.

Parent's Signature _____ Date _____

PAYMENT METHODS:

You may choose one of these methods, or a combination:

1. You may pay by check.
2. You may pay by Visa or Master Card, submitting your credit card information below. We will maintain your account information securely and make automatic charges to your account on the schedule you select. **All credit card information is held only for the current fiscal year, then securely deleted, so it is necessary to resubmit your information each year.** Additional financial commitments made throughout the year will be spread across the remainder of the fiscal year and charged to your account based on the payment schedule you have chosen. (An additional 3.5% is charged to your account for each credit card transaction).

PAYMENT RESPONSIBILITY:

Please Print

Name of First Adult_____ First Adult Daytime Phone_____

Name of Second Adult_____ Second Adult Daytime Phone_____

Credit Card Information (If applicable)

Please bill my credit card **Circle One**

Credit Card Number_____ Expiration Date _____ Visa MC

Name as it appears on card_____ Zip Code of holder _____

Card Holder Signature _____

Payment must be received no later than the child(ren)'s first day of camp.

Pick Up Policy

To maintain the integrity of the program and to respect the hours of operation, the following policy has been put in place. We understand that emergencies arise. We also understand that traffic can be challenging or hectic, but we expect all children to be picked up on time based on the school clock. When your child is picked up late, our staff is required to remain working, and, therefore, unable to attend to commitments outside of their work and with their own families. If a parent/guardian is late for any reason, a late charge will be issued. A "no exceptions" policy makes it easier to apply the late policy to everyone consistently and fairly.

I understand that consistently late pick-ups may result in the removal of my child from the Leonard & Madlyn Abramson ECEC at Tiferet Bet Israel.

Late Pick-Up Policy Fee & Procedure

- First 5 minutes: grace period
- The first 15 minutes: automatic flat $20.00 late fee
- Beyond the first 15 minutes: you will incur a $1.00 per minute late fee

Please sign below to indicate your awareness of this policy. We appreciate your understanding and cooperation in adhering to our policy.

Parent's Signature: _____ Date: _____

Camp TBI Tuition Schedule
4 – Week Session

If selecting a 4-week session, the 4 weeks must be consecutive. You can choose from the following 4-week sessions:

July 13 – August 7 **July 20 – August 14** **July 27 – August 21**

	Days per week	Member Tuition	Non-Member Tuition	Days of Week (Circle)
School Day 9 AM to 3 PM	2 days	$632	$746	M T W Th F
	3 days	$1,846	$999	M T W Th F
	4 days	$1,036	$1,222	M T W Th F
	5 days	$1,126	$1,328	All
Half Day 9 AM to 12 PM	2 days	$375	$443	M T W Th F
	3 days	$534	$630	M T W Th F
	4 days	$610	$720	M T W Th F
	5 days	$686	$810	All

Please sign below as confirmation of your selection.

Parent's Signature: _____ Date: _____

Camp TBI Tuition Schedule
5 – Week Session

If selecting a 5-week session, the 5 weeks must be consecutive. You can choose from the following 5-week sessions:

July 13 – August 14 **July 20 – August 21**

	Days per week	Member Tuition	Non-Member Tuition	Days of Week (Circle)
School Day 9 AM to 3 PM	2 days	$790	$933	M T W Th F
	3 days	$1,058	$1,248	M T W Th F
	4 days	$1,295	$1,528	M T W Th F
	5 days	$1,407	$1,660	All
Half Day 9 AM to 12 PM	2 days	$469	$553	M T W Th F
	3 days	$668	$788	M T W Th F
	4 days	$762	$899	M T W Th F
	5 days	$858	$1,013	All

Please sign below as confirmation of your selection.

Parent's Signature: _____ Date: _____

Camp TBI Tuition Schedule
6 – Week Session
July 13 – August 21

	Days per week	Member Tuition	Non-Member Tuition	Days of Week (Circle)
School Day 9 AM to 3 PM	2 days	$948	$1,119	M T W Th F
	3 days	$1,269	$1,497	M T W Th F
	4 days	$1,688	$1,833	M T W Th F
	5 days	$1,126	$1,992	All
Half Day 9 AM to 12 PM	2 days	$563	$664	M T W Th F
	3 days	$801	$945	M T W Th F
	4 days	$914	$1,079	M T W Th F
	5 days	$1,030	$1,215	All

Please sign below as confirmation of your selection.

Parent's Signature: _____ Date: _____

COVID-19
SPECIAL PROGRAM ATTENDANCE
FAMILY ACKNOWLEDGMENT, DISCLOSURE & DISCLAIMER

Please read and initial each statement below.

1. _____ I understand that during this COVID-19 Public Health Emergency I will NOT be permitted to enter Tiferet Bet Israel Synagogue and its ancillary structures (collectively, the "Synagogue") beyond the designated drop-off and pick-up area. I understand that this change is for the safety of all persons present and to limit to the extent possible everyone's risk of exposure. I understand that it is my responsibility to inform any emergency contact persons of the information contained herein.

2. _____ I understand that IF there is an emergency requiring me to enter the Synagogue beyond the designated drop-off and pick-up area I MUST sanitize my hands before entering, and wear a mask. While in the Synagogue I must practice social distancing and remain no less than 6 feet from all other people, except for my own child and immediate family members accompanying me.

3. _____ I understand that to enter upon the Synagogue my child must be free from COVID-19 symptoms. If, during the day, any of the following symptoms appear my child will be separated from the rest of the people in the Synagogue, I will be contacted, and agree that my child MUST be picked up within thirty (30) minutes of such notification.

   Symptoms include, without limitation:
   - fever of 100.4 degrees Fahrenheit or higher
   - dry cough
   - Shortness of Breath
   - Chills
   - Loss of taste or smell
   - Sore Throat
   - Muscle aches

   While we understand that many of these symptoms can also be related to non-COVID-19 related issues we must proceed with an abundance of caution during this Public Health Emergency. These symptoms typically appear 2-7 days after being infected and as late as 14 days after being infected so please take them seriously. Your child will need to be symptom free **without any medications** including fever lowering medication such as Tylenol, for 72 hours before returning to the facility.

4. _____ I understand and agree that my child's temperature will be taken throughout the day while at the Synagogue.

5. _____ I will immediately notify The Synagogue Camp's administration if: I become aware of any person with whom my child or I have had contact; exhibits any one or more of the symptoms identified in Number 3 above; am advised to self-isolate, quarantine, or has tested positive; or is presumed positive for COVID-19. Further, I shall immediately notify the Synagogue Director if anyone from my place of employment is presumed positive or tests positive for COVID-19 whether or not I have had direct contact with that person.

6. _____ I understand that while present in the Synagogue each day my child will be in contact with children, families and other employees who are also at risk of community exposure to COVID-19. I understand that no list of restrictions, guidelines or practices will remove 100% of the risk of exposure to COVID-19 as the virus can be transmitted by persons who are asymptomatic and before some people show signs of infection. I understand that I play a crucial role in keeping

everyone in the Synagogue's facility safe and reducing the risk of exposure by following the practices outlined herein.

7. Parent(s) for themselves and their child identified below hereby discharge and release the Synagogue, together with its respective officers, directors, staff members, agents, or designees or their respective successors or assigns harmless from and against any and all liability, loss, damages, cost, fine, penalty or expense (including reasonable attorneys' fees and expenses of litigation) of whatever type or nature, in any way connected with any claims, suits, actions, causes of action, demands, or judgments arising out child and/or family child's family members contracting COVID-19 from exposure in, at or about the Synagogue, and/or from use of the Synagogue facility, except for any act or omission of gross or willful misconduct outside the scope of duties assigned to Synagogue's staff member(s) during their respective employment.

I, _____ certify that I have read, understand, and agree to comply with the provisions listed herein. I acknowledge that failure to timely act in accordance with the provisions listed herein, or with any other policy or procedure outlined by the Synagogue will result in termination of services to my child and participation in the program. I acknowledge that care for my child will end if it is determined that my actions, or lack of action unnecessarily exposes another employee, child, or their family member to COVID-19. In signing this Disclosure, together with consideration in allowing my child to participate in the Synagogue's program together with other valuable consideration the receipt and sufficiency of which is acknowledged, I hereby intend to be legally bound thereby.

Child's Name: _____ DOB: _____
[Print Name]

_____ _____
Parent/Guardian Signature Date

_____
Parent/Guardian Printed Name

EMERGENCY CONTACT / PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270.124(a)(b), 3270.181 & 182; 3280.124 (a)(b), 3280.181 & .182; 3290.124 (a)(b), 3290.181 & .182

CHILD'S NAME	BIRTHDATE
ADDRESS	

MOTHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	

FATHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	

EMERGENCY CONTACT PERSON(S)	NAME	TELEPHONE NUMBER WHEN CHILD IS IN CARE

PERSON(S) TO WHOM CHILD MAY BE RELEASED	NAME	ADDRESS	TELEPHONE NUMBER WHEN CHILD IS IN CARE

NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER	TELEPHONE NUMBER
ADDRESS	

SPECIAL DISABILITIES (IF ANY)	ALLERGIES (INCLUDING MEDICATION REACTION)
MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION	MEDICATION, SPECIAL CONDITIONS
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD	
HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENEFITS	POLICY NUMBER (REQUIRED)

PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT

OBTAINING EMERGENCY MEDICAL CARE	ADMIN. OF MINOR FIRST - AID PROCEDURES
WALKS AND TRIPS	SWIMMING
TRANSPORTATION BY THE FACILITY	WADING

PERIODIC REVIEW

SIGNATURE OF PARENT or GUARDIAN _____ DATE _____

SIGNATURE OF PARENT or GUARDIAN _____ DATE _____

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:

☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)

☐ YES ☐ NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3)	
HEARING (subjective until age 4)	
LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:	SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:	TITLE:
PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.